Attachment A

Assessment of Individual Reforms and Their Potential Impact on Outcomes

Note: These descriptions may not reflect the final design details of some reform proposals

Claudia Williams

AZA Consulting
April 29, 2002

Prepared for the California Health Care Options Project

	Brownstein	Brown and Kronick	Harbage
Ease of enrollment Proposal	Enrollment process not specified. Process will likely involve demonstrating income, resident status, ineligibility for public programs and lack of insurance for six months. Focused marketing effort at the county level targeted at employers, temporary staffing firms and other groups. Enrollment in existing public and private coverage as in status quo, but with simplified income-based not categorical public coverage.	Written application for Healthy California (HC) requiring signed declaration of legal residence (and income for those wishing to apply for wrap-around benefits), SSN for applicants and signed declaration that applicants do not have employer-based coverage. Enrollment in employer-based coverage as in status quo.	Individual enrollment process through one-page application. Will likely require documentation of income, demonstration of lack of coverage for 6 months or evidence of meeting exemption, and other information required to screen for Healthy Families and Medi-Cal. Enrollment in existing public and private coverage as in status quo. Program envisions a multi-faceted outreach campaign.
Impact	*Unclear what enrollment process issues might be although number of requirements suggest it may be a complicated process. Targeted marketing of this type of program successful in Santa Clara County. Premiums likely a barrier to enrollment in public programs (logistics of payment and unwillingness to pay). Some potential for stigma in MCEP since income-eligible program - mitigated by increasing eligibility to 400% of FPL but possibly exacerbated by use only of safety net providers. Continuation of multiple intersecting coverage and fragmentation of current system, but with some simplification through income-based eligibility.*	*Although enrollment process streamlined still modest risk that eligibles will not enroll in HC because of paperwork requirements. Continuation of both private coverage and Healthy California, much simpler than today, but there is still modest risk of fragmentation.*	*The enrollment and eligibility process may be complicated since both the employer and the employee must be involved. Risk that eligibles will not enroll in CPPP because of paperwork requirement and possibility of stigma since low-income only program. This stigma may be reduced by use of private coverage. Continuation of multiple intersecting coverage and fragmentation of current system.*
Usual source of care Proposal	No specified process for establishing usual source of care in MCEP. Status quo in existing public and private coverage. Both Medi-Cal and Healthy Families have mechanism for establishing a usual source of care.	No specified process for establishing usual source of care. Status quo in private coverage.	No specified process for establishing usual source of care. Process for establishing usual source of care will vary by employer and plan. Status quo in existing private and public coverage.
Impact	*As today, some subset of covered will not establish a usual source of care. In addition, insurance transitions will disrupt usual source of care.*	*As today, some subset of covered will not establish a usual source of care. In addition, transition from employer coverage to HC may disrupt usual source of care.*	*As today, some subset of covered will not establish a usual source of care. In addition, insurance transitions will disrupt usual source of care.*
Benefits Proposal	MCEP will have current Healthy Families benefits, which include dental and vision care. Status quo benefits for those in existing private and public coverage. Medi-Cal will retain rich benefits, which include support services.	Benefits will vary in private coverage although will need to match the actuarial value of HC. HC will have current Healthy Families benefits, which include vision and dental with access to enhanced services including support services for low-income households.	Benefits will vary in new private coverage although will need to match the actuarial value of one of 4 benchmarks. Status quo benefits for those in existing public and private coverage. Medi-Cal will retain rich benefits, which include support services.
Impact	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale (Those with high incomes may have richer benefits through employer - those with low-incomes will have access to the full Medi-Cal benefit package.) Benefits still variable in private coverage.*	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still variable in private coverage although will need to meet actuarial value of HC.*	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still variable in private coverage. New coverage will meet actuarial value of benchmark.*
Cost sharing Proposal	Cost sharing per status quo in existing employer based and public coverage. MCEP has fairly nominal ($5-$10) copays for all services with an out-of-pocket limit of $250.	HC has nominal ($5) copays for outpatient services and prescription drugs – but not for inpatient or prev entive care. No out-of-pocket limit. Cost sharing in existing employer based coverage cannot exceed HC levels.	Cost sharing per status quo in CPPP (based on existing private plans) and in existing private and public coverage.
Impact	*Modest copays in MCEP will depress use of some services including preventive care. This is mitigated by out-of-pocket limit. Risk of access barriers from cost-sharing in private coverage where copayments and deductibles will vary.*	*Exemption of preventive services from copays for HC will mitigate risk of cost-sharing, although modest copays will depress use of some services. This could be addressed by adding an out-of-pocket limit.*	*Copayments and deductibles will vary and have the potential to limit access to services.*
Access to providers *Proposal*	MCEP will rely on current Medi-Cal managed care provider system. Reimbursement rates per status quo. Provider access per status quo for existing private and public coverage.	No specific provisions related to provider availability, network capacity, provider choice or access to specialists. Author makes indirect reference to the possible need to increase reimbursement rates stating that public coverage funding will have to increase in order to maintain access to care. Provider access per status quo for existing private coverage. MRMIB may use direct contracting for services. Employees can choose between available employer plan and HC.	No specific provisions related to provider availability, network capacity, provider choice or access to specialists. Reimbursement rates per status quo. Provider access per status quo for existing private and public coverage.
Impact	*Risk that safety net capacity will be insufficient or poorly distributed for populations with different demographics than those now enrolled. Current problems related to distribution and availability of providers, relatively low reimbursement for public coverage and limits on direct access to specialists continue.*	*Current problems related to distribution/availability of providers and limits on direct access to specialists continue. Possibility of improved access to providers for those in HC from potentially higher reimbursement rates.*	*Current problems related to distribution and availability of providers, relatively low reimbursement for public coverage and limits on direct access to specialists continue. Some protection afforded by insurance laws which mandate a certain level of access to providers, but problems still occur.*
Gaps in coverage Proposal	Gaps from 6-month waiting period for MCEP, insurance transitions due to employer-based coverage, ineligibility for MCEP due to income and inability to pay premiums. Waiting period applies to voluntary coverage termination by employer/employee. Laid-off workers eligible immediately.	No gaps in coverage envisioned, unless a person has failed to enroll in HC.	Gaps in coverage for subset of population caused by 6-month waiting period for enrollment in CPPP, requirement that only small employers can participate, and insurance transitions related to employer-based coverage and inability to pay premiums.
Impact	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*	*Minimal anticipated access risk or threat to continuity of care from gaps in coverage.*	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Ease of enrollment Proposal	Enrollment process not specified – but will likely involve only documenting state residence for three months or longer. Proposal envisions public service campaign to encourage enrollment.	Enrollment process not specified – but involves proof of residence, demonstration of working status, mechanism for verifying income and paying premium. Cov erage for one year with renewal guaranteed with payment of premium. Enrollment in existing public and private coverage as in status quo. Media campaign and community outreach to enroll eligibles.	Simplifies and streamlines the application process for public coverage by eliminating assets test, 12 months eligibility for some groups, simplifying the application, launching outreach and implementing presumptive eligibility for all groups. Enrollment in existing public and private coverage as in status quo but with simplified income-based not categorical eligibility.
Impact	One-time only enrollment and little paperwork will address most enrollment barriers. Little risk of stigma because everyone covered by one program.	*Some enrollment barriers will exist for CHOICE because of need to meet eligibility requirements. Mitigated by one-time eligibility. Continuation of multiple intersecting coverage and fragmentation of current system, but with a consistent alternative choice for those who work.*	*These strategies may result in greater enrollment and retention in public programs although still some risk of barriers to enrollment and risk of stigma since low-income only program. Continuation of multiple intersecting coverage retains fragmentation of current system, although with some simplification through income-based eligibility.*
Usual source of care Proposal	Individuals will formally designate a provider at enrollment if they select a prepaid provider. No specified process for selecting a usual source of care if fee-for-service providers used.	Enrollees in CHOICE select a PCP whose performance is monitored regarding delivery of preventive services and disease management. Enrollees may change their PCP at beginning of any month. Status quo for those in private and public coverage. Both Medi-Cal and Healthy Families have mechanism for establishing a usual source of care.	Both Medi-Cal and Healthy Families have mechanism for establishing usual source of care. Status quo in existing private coverage.
Impact	*Modest risk, as today, some enrollees will not establish a usual source of care. Little to no risk of insurance transitions.*	*CHOICE may result in better establishment and performance of usual source of care. Enrollees will be able to avoid insurance transitions by remaining in the CHOICE plan.*	*As today, some subset of covered will not establish a usual source of care. In addition, insurance transitions will disrupt usual source of care.*
Benefits Proposal	Benefits including transportation for disabled, language interpretation, education and screening services, and long term care. *Access to care facilitated by broad definition of benefits. However, services only covered if deemed medically necessary – unclear how or who will define this.*	Uses the Kaiser plan large group benefits as benchmark. In CHOICE, benefits include vision care and health education but not dental care or other supportive services. Status quo benefits for those in private and public system. Medi-Cal will retain rich benefits, which include support services. *For CHOICE, broad benefits. Benefits only covered if deemed medically necessary – unclear how or who will define this. Risk of tiered system with richer benefits for those at top and bottom of income scale. Benefits still variable in private coverage.*	Benefits in the expanded public program relatively rich (current Health Families and Medi-Cal which include dental and vision). Status quo benefits in existing public and private coverage. Medi-Cal will retain rich benefits, which include support services. Limited benefits and very high deductible for the new employer coverage program.
Impact			*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still very variable in private coverage.*
Cost sharing Proposal	Nominal $5 copays for outpatient services and prescription drugs, and $100 for hospital stays, with no out-of-pocket limit. *Copays in MCEP will depress use of some services including preventive care. This is mitigated by exemption of persons who qualify for Medi-Cal and could be further addressed through introduction of an out-of-pocket limit.*	Cost sharing per status quo in existing employer based and public coverage. For CHOICE no copayments for poor and for preventive services in network. Higher income enrollees have $10 copay for outpatient, $35 for ER visits and 4-tier copayment schedule for prescription drugs with no out-of-pocket limit.	Cost-sharing per status quo in existing employer-based and public coverage. Assume Medi-cal and Healthy Families expansions will embrace current cost-sharing policies. New employer coverage may have cost sharing with no cap and a very high deductible.
Impact		*Exemption of low-income enrollees and preventive services from copays will mitigate risk although copays will depress use of some services. This could be mitigated by adding an out-of-pocket limit. Risk of access barriers from cost-sharing in private coverage where copayments and deductibles will vary.*	*Copayments and deductibles will vary and have the potential to limit access to services.*
Access to providers *Proposal*	Patients who opt into "managed care" (providers are prepaid) must remain in network. Patients who choose fee-for-service providers will have choice of providers including direct access to specialists. Reimbursement at current average.	Providers will be paid at Medicare rates. Enrollees have direct access to providers including specialists. Status quo access for those in current private and public coverage.	Status quo for access to providers. No change envisioned to reimbursement rates.
Impact	*Provider access for people with low incomes may increase since reimbursement rates will be better than current Medi-Cal rates. With free choice of providers provides direct access to specialists. Current problems related to distribution of providers continue.*	*Provider participation in CHOICE likely better than today because of improved reimbursement rates. Enrollees in CHOICE will have ready access to providers with no restrictions or referral requirements. Access problems may continue in current private and public programs. Current problems related to distribution of providers continue.*	*Current problems related to distribution and availability of providers, relatively low reimbursement for public programs and limits on direct access to specialists continue. Provider access problems may arise for disabled population in Medi-Cal who transition to managed care.*
Gaps in coverage Proposal	No gaps in coverage except resulting from one-time three-month waiting period.	Gaps in coverage for subset of the population caused by insurance transitions related to employer-based coverage, inability to pay premiums and employment requirements.	Gaps caused by waiting period for Healthy Families, insurance transitions related to employer-based coverage, ineligibility due to high income and inability to afford premiums for public as well as private coverage.
Impact	*Minimal access risk or threat to continuity of care from gaps in coverage.*	*Some risk of discontinuity of care and disruption in usual source of care from coverage gaps, although mitigated by simplified coverage system.*	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*

	Shaffer	Spelman	Wulsin
Ease of enrollment Proposal	Author does not specify the details of the enrollment process, but would likely involve only documenting state residence for six continuous months. The CHS administrator charged with developing efficient mechanisms for assuring eligibility and enrollment. Media and outreach campaign envisioned.	Author outlines enrollment process including simplified enrollment, automatic enrollment of newborns, and enrollment at point of contact with healthcare system. Enrollment at multiple locations, community outreach and media announcements envisioned.	Enrollment process not specified for public coverage. Assume current rules continue but with simplified income-based not categorical eligibility. No need for new application when people move between Healthy Families and Medi-Cal.
Impact	*One-time enrollment and little paperwork will address most enrollment barriers. Little risk of stigma because everyone covered by one program.*	*One-time only enrollment and little paperwork will address most enrollment barriers. Little risk of stigma because everyone covered by one program.*	*As today, some risk of enrollment barriers in public programs. Potential for stigma since it is a low-income only program. Continuation of multiple intersecting coverage and fragmentation of current system. Much simplification of enrollment in public coverage because of income-based (rather than categorical) eligibility and consolidation of multiple programs into two – Healthy Families and Medi-Cal.*
Usual source of care Proposal	Author states that each person will have a primary caregiver, but does not specify a process or incentives for establishing or maintaining one. Care coordination assigned to each group practice.	The author states that the plan will include system-wide primary care case management and referral. At enrollment, and at all points of interaction with healthcare system, there will be a mechanism for linking enrollees with a usual source of care.	Proposal does not affect status quo in private or public coverage. Both Medi-Cal and Healthy Families have mechanism for establishing usual source of care.
Impact	*Establishing a usual source of care for every enrollee is a goal of the program, however it is somewhat unclear how this will occur.*	*Iterative process will reinforce establishment of a usual source of care.*	*As today, some subset of covered will not establish a usual source of care. No plan to address this. In addition, insurance transitions will disrupt usual source of care.*
Benefits Proposal	Uniform benefit package includes dental, vision, home health, acupuncture and chiropractic care. Support services such as transportation and translation/interpretation not reimbursed.	Uniform benefit package includes limited vision, dental, and long term care as well as alternative medicine services. Implementation of a closed formulary for prescription drugs. Translation/interpretation and transportation are covered along with behavior change interventions such as weight control, nutrition counseling and exercise classes.	Benefits will vary depending on the type of coverage, although only plans meeting minimum bar of benefits (which does not include vision or dental) will be eligible for tax subsidies. Those in Medi-Cal and Healthy families will maintain current program benefits (including dental and vision and support services for Medi-Cal) but current optional Medi-Cal groups will transition to Healthy Families coverage.
Impact	*Broad benefits. Potential for modest access problems, especially for low-income due to lack of support services.*	*Broad benefits, coverage of behavior change, and inclusion of translation and transportation should have a positive impact on access especially for low-income group. Depending on implementation - closed drug formulary could have a negative impact on access to prescription drugs.*	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still very variable in private coverage. Loss of Medi-Cal benefits (including support services) for some low income groups transitioning to Healthy Families.*
Cost sharing Proposal	No copayments or deductibles in current plan.	No copayments or deductibles in plan.	Copays for those in public coverage will be at current levels, which are relatively nominal.
Impact	*No limitation on access to care from cost-sharing.*	*No limitation on access to care from cost-sharing.*	*Modest copays in public coverage and for Knox Keene plans (only Knox Keene qualify for tax subsidies) and will depress use of some services including preventive care. Copayments and deductibles in other private coverage will vary.*
Access to providers Proposal	Assumption that most if not all providers will participate in the plan. Enrollees will have free choice of providers for services with no limits on access to specialists. Proposal includes plan to redistribute providers to create more access in underserved areas and increase number of primary care providers relative to specialists.	Assumption that most if not all providers will participate in the plan. Primary care case management system will include a required referral for access to specialty care, but with the option of specialty management of certain conditions. The budget, and presumably provider reimbursement, will increase at the rate of GDP plus population growth. The overall approach will include a mechanism for tracking distribution of resources to identify inequities.	Status quo for access to providers. No change envisioned in reimbursement rate.
Impact	*Enrollees will generally have ready access to providers with no restrictions or referral requirements. Rebalancing primary care and specialist capacity will likely increase availability of primary care and may reduce availability of specialty care. Provider shortages would be monitored by patient representatives. Plan recognizes and addresses need to increase rural access with large-scale efforts to assign providers to underserved areas.*	*Enrollees will have ready access to providers although with possibility of referral requirements. The presumed limitation on growth rate of reimbursement to GDP plus population growth may mean lower overall reimbursement growth relative to other areas of country without these limitations. This could affect the CA provider supply. Alternatively, simpler administration, more control over decision-making and risk-adjustment might attract providers. Plan will use financial incentives to create better distribution of providers.*	*Current problems related to distribution and availability of providers, relatively low reimbursement rates for public coverage and limits on direct access to specialists will continue. Provider access problems may arise for disabled population in Medi-Cal who transition to managed care.*
Gaps in coverage Proposal	No gaps in coverage except resulting from one-time six-month waiting period for new residents.	No gaps in coverage except resulting from one-time three-month waiting period. Those not eligible because of waiting period will be provided services if they present for care.	Gaps caused by waiting period for Healthy Families (although there are exceptions for all but those voluntarily dropping coverage), insurance transitions related to employer-based coverage, ineligibility due to high income and inability to afford premiums. Increase of public program eligibility will decrease transitions for low-income group.
Impact	*Minimal access risk or threat to continuity of care resulting from gaps in coverage.*	*Minimal access risk or threat to continuity of care resulting from gaps in coverage.*	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*

	Brownstein	Brown and Kronick	Harbage
Preventive Care Proposal	As in Healthy Families, preventive services covered in MCEP but may be subject to cost-sharing. Status quo for coverage of preventive care in private and public coverage.	Wide range of preventive services are covered and are not subject to cost-sharing. Status quo for coverage of preventive services in private coverage except plan has to meet actuarial value.	Preventive services not necessarily covered. If covered, may be subject to cost-sharing.
Impact	*This plan would result in increased coverage and utilization of preventive services, although use may be depressed due to cost-sharing. The plan would not necessarily result in a shift of resources toward primary and preventive care.*	*This plan would result in increased coverage and utilization of preventive services. Would not result in a shift of resources toward primary and preventive care.*	*Use of private managed care entities may increase use of preventive services, since managed care more likely to cover these benefits than fee-for-service coverage. Varies by plan.*
Quality of Care Proposal	No specific quality of care strategies outlined. Author states that the county plans will be responsible for quality assurance and that quality control will be addressed by using safety net institutions, which have charitable missions. The accountable entity for quality improvement could be the contracting health plans. Status quo for quality in existing public and private coverage.	The implementing agency, MRMIB, will create an office of quality assessment with an advisory board to include all system stakeholders. This office will collect data from health plans and providers and issue reports. Status quo for quality in private coverage. The accountable entity for quality improvement will be the health plan.	Pac-Advantage has quality improvement efforts. Status quo for quality in private and public coverage.
Impact	*This proposal would not directly change or influence the quality of care in the health care system. Reliance on Medi-Cal contracting mechanisms may positively influence quality of care since these programs have more mechanisms to track and monitor quality than is typically found in private coverage, although it does not appear MCEP will necessarily use this infrastructure. Not clear that safety net providers offer better quality of care than other providers.*	*The author includes some of the elements of a quality continuum, although difficult to assess the scope. Based on description would likely be comparable to the level of quality information and improvement efforts in the Medi-cal program.*	*This proposal would not substantially change or influence quality of care in the health care system.*
Patient Education Proposal	Status quo for patient education. County management of plan implementation may provide more opportunities for consumer input.	Status quo for patient education. Covers a number of behavior change interventions such as smoking cessation drugs and substance abuse treatment.	Status quo for patient education.
Impact	*This proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Continuation of managed care approaches throughout system will maintain existing third party intervention in the patient/provider relationship.*	*This proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Reliance on Healthy Families may positively influence patient education since contracted plans may have more mechanisms to promote patient education than are found in private coverage. Continuation of managed care approaches throughout system will maintain existing third party intervention in the patient/provider relationship.*	*This proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Continuation of managed care approaches throughout system will maintain existing third party intervention in the patient/provider relationship.*
Innovation Proposal	Status quo for innovation and technology.	Status quo for innovation and technology.	Status quo for innovation and technology.
Impact	*No changes anticipated from this program.*	*No changes anticipated from this program.*	*No changes anticipated from this program.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Preventive Care Proposal	Covers preventive services although subject to cost-sharing. Earmarked funding to advance public health and prevention.	CHOICE covers preventive care services with exemption from cost-sharing. Evidence-based benefits will focus on primary prevention and early disease identification and treatment. Primary care providers will be held accountable for preventive care utilization of their patients. Not clear how this will be enforced or incented. Electronic claims will be used to track provider performance on quality of care including delivery of preventive services. Status quo for private and public coverage.	Preventive services covered in private and public coverage options. Not clear if these are covered in new scaled-back employer offerings. Status quo for cost-sharing.
Impact	*This plan would result in increased coverage and utilization of preventive services, although use may be somewhat depressed due to cost-sharing. Would not necessarily result in a shift of resources toward primary and preventive care, although does provide some set-aside funding.*	*This plan would result in increased coverage and utilization of preventive services and greater emphasis on primary and preventive care, especially if provider incentives are effective. There could be a shift of resources to primary and preventive care if the evidence-based benefits motivate substantial changes in practice.*	*This plan would lead to increased coverage and utilization of preventive services although use may be somewhat depressed due to cost-sharing.*
Quality of Care Proposal	The author states that the plan will improve quality of care through improved data and analysis of health care patterns and outcomes. The author does not specify how this will be accomplished. Not clear how plan will hold individual physicians accountable for quality of care without accountable entity. The plan will include a stakeholder advisory group addressing quality and clinical guidelines.	CHOICE participating providers will be required to provide data on quality and participate in quality studies. Electronic clearinghouse for claims processing. Incentives for patients to use high quality/low cost providers but no specification of these. Also states that high quality providers will be "recognized". Proposal would implement centers of excellence for certain high cost procedures for which there is a link between volume and quality. CHOICE will only contract with providers meeting minimum standards.	Status quo for quality.
Impact	*Based on the information provided it is difficult to assess what the quality improvement interventions would be or how they might affect quality of care.*	*For the CHOICE program, the author incorporates most of the elements of the quality continuum from improving information and data to tracking performance, publishing and disseminating quality information and creating mechanisms for performance-based contracting through centers of excellence. Still, it is very difficult to evaluate the effectiveness and likely impact of these approaches.*	*This proposal would not directly change or influence the quality of care in the health care system. Reliance on Medi-Cal and Healthy Families may positively influence quality of care since these programs have more mechanisms to track and monitor quality than are found in private coverage.*
Patient Education Proposal	Will remove the third party intervention between doctor and patient present in today's health care system. This may result in more open communication and better relationships between providers and patients. Behavior change interventions included on list of covered services. Outreach and education services are funded.	Emphasis on provider accountability for preventive care and focus on disease management and self-care will likely translate into greater emphasis on patient education. CHOICE providers also required to launch patient education efforts and reminders to encourage appropriate care. Author states that there will be health education including all media taking into account individual characteristics such as language, disability and cultural perspective. The program will also invest in educational products allowing patients to make informed selection of treatment options. Status quo for those in private or public coverage.	Status quo for patient education.
Impact	*Improved outlook for patient/provider relationship. Budget based facility payment may provide new opportunities for population and public health approaches, however, not clear how these changes might be organized. Author does not outline increased investment in public health approaches but does finance some individual behavior change interventions.*	*The proposal emphasizes patient education, incenting providers to deliver patient education and prevention services and using a variety of public health oriented community education approaches to behavior change. While they are not explicitly covered, it is possible that direct behavior change interventions (weight loss, smoking cessation) would be funded under the disease management program. Within CHOICE, would remove the third party intervention between doctor and patient.*	*Again, this proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Reliance on Medi-Cal and Healthy Families may positively influence patient education since these programs have more mechanisms to promote patient education than are found in private coverage. Continuation of managed care approaches throughout system will maintain existing third-party intervention in the patient/provider relationship.*
Innovation Proposal	Separate capital budget. Capital spending in excess of $750,000 requires approval. All capital improvements funded through the capital budget will remain the property of the state of California. Earmarked funding for innovative technologies.	Proposal includes an evidence-based benefits approach.	Status quo for innovation and technology.
Impact	*With use of capital budgets and approval process, along with presumed limits on spending growth, this approach may reduce demand for and supply of some technologically advanced interventions, although production of other technologies (those linked to health goals) may increase.*	*Possibility of lowered availability of some high technology services due to evidence-based approach to benefits. This approach could also promote the development of more cost-effective innovations.*	No changes anticipated from this program.

	Shaffer	Spelman	Wulsin
Preventive care Proposal	Covers preventive services with no cost-sharing. The program aims to achieve a higher ratio of primary to specialty physicians. DPH and OSHPD track and address determinants of poor health.	Covers preventive services with no cost-sharing. Health services budget includes funding for prevention and education. The approach includes financial incentives to assure broad implementation of population-health and prevention strategies.	Preventive services covered in private and public coverage options. Status quo for cost-sharing.
Impact	*This plan would result in increased coverage and utilization of preventive services and a shift in resources toward primary and preventive care through changing the physician mix.*	*This plan would result in increased coverage and utilization of preventive services. Required use of primary care doctors as first point of contact and increased reimbursement for these physicians likely to increase primary and preventive care use.*	*This plan would result in increased coverage of preventive services, but use may be depressed due to cost-sharing.*
Quality of Care Proposal	The author states that the CHS will have the ability to increase the collection and dissemination of clinical information, but does not specify how this will be done except indicating that results will be shared with peers and public. Hospitals will develop processes to improve patient-safety. CHS will include a provider-led initiative to develop evidence-based guidelines and group practices will select quality measures for clinical improvement. The medical groups provide a ready accountability unit, although not clear what the carrots and sticks would be to generate better quality.	The proposal includes a number of quality of care initiatives including electronic data interchange, electronic patient records, physician performance data, development and tracking of standards of care/best practice standards in conjunction with clinical advisory groups, peer review of provider practices, public access to performance information and system to monitor results.	Status quo for quality. Existing quality improvement efforts in private and public programs would continue. Health plan could be the accountable entity for a quality improvement effort.
Impact	*The author includes some elements of the quality continuum including developing quality standards in collaboration with physicians. Quality performance information will be disseminated to the public. The capabilities of the information system are not specified. There would not be a means to reward or offer preferential contracting to better performing providers.*	*This author includes many elements of the quality continuum. Many of these have been successfully implemented elsewhere, but they have never been collectively introduced at a system level. Given the complexity of this proposition, it is difficult to evaluate the effectiveness and likely impact of this approach.*	*This proposal would not introduce new mechanisms for improving health care quality. Reliance on Medi-Cal and Healthy Families may positively influence quality of care since these programs have more mechanisms to track and monitor quality than are found in private coverage.*
Patient Education Proposal	Will remove the third party intervention between doctor and patient. This may result in more open communication and better relationships between providers and patients. CHS would also use patient advisory groups in each community to set program objectives. Patient representatives are elected, paid and staffed. The Department of Public Health would be responsible for implementing public health programs with the Office of Community Health Services charged with community outreach and health education. A goal for clinician practices is to maximize patient involvement in treatment decisions. This is accomplished through consumer participation in setting quality goals, use of care coordinators and implementation of patient decision-making boards.	Will remove the third party intervention between doctor and patient. This may result in more open communication and better relationships between providers and patients. Each county will have a consumer advocate office, a county health officer and regional boards of county health system stakeholders. A number of behavior change interventions are covered. Health planning could involve public health approaches to health care improvement. Health services budget includes funding for prevention and education.	Status quo for patient education.
Impact	*Improved outlook for patient/provider relationship. Author assigns public health responsibilities to a division of HHS responsible for direct service delivery which may result in integration of public health and direct health care services. Transition to salary based physician payment for physicians and budgets for facilities affords the opportunity for increased attention to population and public health approaches, however not clear how these changes might be triggered and organized. The Department of Public Health is given increased authority under the plan. Proposal does not finance behavior change interventions.*	*Improved outlook for patient/provider relationship. Author funds increased investment in health planning and prevention and education. Proposal also finances individual behavior change interventions, which will likely increase use of these services. Budget based facility payment may provide new opportunities for population and public health approaches, including funding for training primary care doctors in population-health.*	*This proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Reliance on Medi-Cal and Healthy Families may positively influence patient education since these programs have more mechanisms to promote patient education than are found in private coverage. Continuation of managed care approaches throughout system will maintain existing third-party intervention in the patient/provider relationship.*
Innovation *Proposal*	Separate capital budget. Office of Reimbursement assigned to manage allocation process, although details not specified.	Construction, renovation and major equipment would be financed by regional global capital budgets. Author states that maintaining the number and diversity of producers to encourage innovation research is a priority. System of public/private partnerships to incent innovation linked to health goals.	Status quo for innovation and technology.
Impact	*With use of capital budgets and approval process, along with presumed limits on spending growth, this approach may reduce demand for and supply of some technologically advanced interventions, although production of other technologies (those linked to health goals) may increase.*	*With use of capital budgets and approval process, along with limits on spending growth, this approach may reduce demand for and supply of some technologically advanced interventions, although production of other technologies (those linked to health goals) may increase.*	No changes anticipated from this program.

	Brownstein	Brown and Kronick	Harbage
Preservation of safety net funding Proposal	No change to charity care funding except to count new MCEP enrollees in formula for DSH payments.	No change to charity care funding.	No change to charity care funding.
Impact	*Current mechanisms for charity care funding remain in place – presumption that resources available for each uninsured person would remain constant or increase. MCEP likely to generate significant additional resources for safety net.*	*Current mechanisms for charity care funding remain in place – presumption that resources available for each uninsured person would remain constant or increase.*	*Current mechanisms for charity care funding remain in place – presumption that resources available for each uninsured person would remain constant or increase.*
Contracting position of safety net providers Proposal	The contracting mechanism for MCEP will be quite similar to that for Medi-Cal managed care except that all enrollees residing in two-plan counties will be enrolled in the local initiative (e.g., they will not have the choice of a commercial plan) which contracts mainly with safety net providers. Local initiatives exist in 12 California counties covering more than half of the state's population.	No specified mechanism for contracting with safety net providers.	No specified mechanism for contracting with safety net providers.
Impact	*Safety net providers will have a highly favored contracting position under the MCEP program. Current favored contracting position of safety net providers in Medi-Cal/SCHIP remains.*	*Enrollees with employer-based coverage may not have access to safety net providers. Those in the public program will likely have access to these providers but there are no mechanisms to favor or prioritize them in the contracting process. Safety net providers' advantageous contracting position under Medi-Cal would be eliminated since Medi-Cal will be merged with Healthy Families to form Healthy California.*	*Enrollees with employer-based coverage may not have access to safety net providers, unless employers choose the purchasing pool option. Current favored contracting position of safety net providers in Medi-Cal/Healthy Families remains.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Preservation of safety net funding Proposal	Eliminates most dedicated funding for charity care (DSH, Realignment, and state categorical programs such as Ryan White) and allocates these funds to expansions. Also eliminates county charity care funds "to the extent not needed for residual safety net services care" – but not clear how this is evaluated.	Eliminates DSH. Continues same level of payment per capita for state and county indigent care ($1,400).	For each uninsured person who becomes covered under the proposal, 70% of the funding for uninsured care (Realignment, county indigent care but not DSH) would be allocated to cover expansions.
Impact	*Significant reduction in the amount of dedicated funding available for charity care, although includes mechanism for evaluating whether funding still needed. The residual uninsured group likely to be very small.*	*Reduction in the amount of dedicated funding available for charity care but gauged to track decrease in uninsured.*	*Some reduction in safety net funding, but gauged to track decrease in uninsured.*
Contracting position of safety net providers Proposal	Safety net providers will likely be included in the networks/plans under the single payer system but will not have a favored contracting position.	Safety net providers will have a favored contracting position since Medi-Cal's COHS plans and LI plans are among the few plans offered contracts.	Safety net providers will have a favored contracting position to some degree within the public program expansion since Medi-Cal offers preferential contracting to these providers.
Impact	*Safety net providers will not have a favored contracting position for new enrollees and will lose their current favored position under Medi-Cal and S-CHIP. This may result in a movement away from these providers.*	*Safety net providers will have a favored contracting position under the CHOICE program.*	*Safety net providers will have a moderately favored contracting position under this proposal.*

	Shaffer	Spelman	Wulsin
Preservation of safety net funding Proposal	Eliminates all, or nearly all (DSH, Realignment, county uninsured funds) dedicated government funding for charity care. Wraps this funding into financing for new coverage.	Eliminates all dedicated government funding for charity care. These resources wrapped into financing for Cal Care.	Increases federal match for current charity care funding. These resources (current spending and match) used to expand coverage. DSH as a source of uninsured funding is eliminated. Other sources of funding for uninsured services (Proposition 99 and Realignment) reduced proportionately with decrease in uninsured.
Impact	*Significant reduction in the amount of dedicated funding for charity care for any residual uninsured group. This group likely to be very small.*	*Elimination of dedicated funding for charity care for any residual uninsured group. This group likely to be very small.*	*Reduction in the amount of dedicated funding for charity care, but gauged to track decrease in uninsured.*
Contracting position of safety net providers Proposal	Safety net providers will likely be included in the networks/plans under the single payer system but will not have a favored contracting position.	Safety net providers will likely be included in the networks/plans under the single payer system but will not have a favored contracting position. School clinics would be funded under Cal-Care.	Safety net providers will have a favored contracting position to some degree within the public program expansion since Medi-Cal offers preferential contracting to these providers.
Impact	*Safety net providers will not have a favored contracting position for new coverage and will lose their current favored position under Medi-Cal and Healthy Families. This may result in a movement away from these providers.*	*Safety net providers will not have a favored contracting position for new enrollees and will lose their current favored position under Medi-Cal and Healthy Families. This may result in a movement away from these providers.*	*Safety net providers will have a favored contracting position under this proposal.*

	Brownstein	Brown and Kronick	Harbage
Immigrants and ethnic minorities Proposal	Undocumented immigrants are covered. County plans will be responsible for cultural and linguistic services.	Undocumented immigrants not covered. No specific coverage of translation/interpretation service.	Undocumented immigrants can participate in CPPP. No specific coverage of translation/interpretation.
Impact	*Main advantage of plan is providing coverage regardless of immigration status. Those covered will benefit from linguistic services and capabilities of safety net providers in providing culturally competent services.*	*Undocumented immigrants likely to remain uninsured. Author states that part of the quality assurance role will involve assuring the availability of culturally competent services. Not clear how this will be accomplished. Lack of funding and reimbursement for translation/interpretation could be problematic.*	*Plan will provide coverage regardless of immigration status, although cost of coverage may still be barrier to immigrant enrollment. Lack of funding and reimbursement for translation//interpretation could be problematic.*
Persons with special health care needs Proposal	Care provided through managed care with attendant restrictions on access to services. Enrollees will likely not have direct access to specialists. Not clear from description of benefits how comprehensive or rich benefits will be. Author does not include a disease management or care management approach for people with special health care needs. Out-of-pocket cap on cost-sharing. Plan payments are not risk-adjusted.	Care provided through managed care with attendant restrictions on access to services. Enrollees will likely not have direct access to specialists. Disabled persons currently enrolled in Medi-Cal will transition from fee-for-service to managed care. Public enrollees meeting former Medi-Cal eligibility will retain Medi-Cal benefits. Others will have Healthy Families benefits. No out-of-pocket limit on cost-sharing in public program. Cost-sharing per status quo in private coverage. Option for PPO rather than managed care network for a higher price in HC. Plan payments are not risk-adjusted.	No specific provisions related to persons with special health care needs. Cost-sharing per status quo. Benefits will need to meet one of 4 benchmarks.
Impact	*Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.) within the MCEP and private coverage and continued variability of benefits in employer coverage may generally limit access to services for people with special health care needs. Poor and disabled protected by continuation of Medi-Cal and Healthy Families programs. No mechanism in MCEP to manage care of persons with special health care needs, although may be able to use the approaches already developed for Medi-Cal.*	*Disabled group transitioning to managed care may experience transition issues and potentially reduced access to services. Poor disabled protected by continuation of Medi-Cal benefits. Those enrolled in HC will benefit from disease and care management experience of Healthy Families contracted health plans. Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.), and variability of benefits in employer coverage may generally limit access to services for people with special health care needs.*	*Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.), and variability of benefits in employer coverage may generally limit access to services for people with special health care needs. Poor disabled protected by continuation of Medi-Cal and Healthy Families programs. Lack of care management or disease management mechanism may create inappropriate or disjointed care for persons with special health care needs.*
Rural populations Proposal	For MCEP fee-for-service maintained in rural areas that cannot support managed care and reimbursement rates improved from current Medi-Cal levels in these areas. Implementation through counties may allow for more sensitive and appropriate interventions to address rural health access issues. Provider access per status quo for those in private plans.	No particular provisions to address rural health care issues.	No particular provisions to address rural health care issues.
Impact	*The higher reimbursement rates and opt out from managed care for rural areas will address potential access issues for those in MCEP. Lack of reimbursement for transportation could pose issues.*	*Healthy Families opts out of managed care in some rural areas. This will address potential rural access for those in HC. Lack of reimbursement for transportation could pose issues. For those in private coverage provider access per status quo in rural areas. Use of managed care in private coverage may exacerbate rural access issues.*	*Provider access per status quo in rural areas. Lack of reimbursement for transportation could pose issues. Use of managed care in private coverage may exacerbate rural access issues.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Immigrants and ethnic minorities Proposal	Undocumented immigrants are covered, along with translation services.	Undocumented immigrants are covered. No specific coverage of translation/interpretation service. Reliance on plans (including Kaiser) which author indicates have been effective providing culturally competent and linguistically appropriate care.	Undocumented immigrants are not covered by public program expansions but can participate in affordable plan offerings. Funding of translation/interpretation and services to assure culturally competent and linguistically appropriate care available for those in Medi-Cal expansion – but no assurances for those with other coverage.
Impact	*Main advantages of plan are providing coverage regardless of immigration status and reimbursing translation/interpretation services. Acculturation to health system may be easier in single player health system.*	*Main advantage of plan is providing coverage regardless of immigration status. Lack of funding and reimbursement for translation/interpretation could be problematic.*	*Substantial subgroup of immigrants likely to remain uninsured because of limited mechanisms to cover them. New plan offerings may offer some relief, but would not be appropriate for persons with acute or chronic health care needs. Lack of funding and reimbursement for translation/interpretation could be problematic in private coverage.*
Persons with special health care needs Proposal	Patients can choose any provider. Comprehensive benefits and no cost-sharing. Budgets will be adjusted for case mix and to account for population need. Risk-adjustment to providers in groups, hospitals and IHDS. Managed care will be an option for patients through IHDS, but use of them not required.	Within CHOICE patients can choose any provider with no referral requirements for specialty care. Author envisions special disease management for those with certain conditions, presumably also allowing specialist primary care management. Patient incentives if disease management program maintained. Author does not specify what these would be. Cost-sharing waived or reduced for those participating in disease management programs. However, no out-of-pocket max and cost-sharing still per status quo for those remaining in public and private coverage. Dental benefits not covered. Capitation payments to plans will be risk-adjusted.	Author does not directly address this area.
Impact	*Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Comprehensive benefit package particularly beneficial for persons with special health care needs. However, cost-sharing may limit access to services for people with special health care needs. Depending on how implemented, requirement to document medical necessity may create barriers to services. Lack of care management or disease management mechanism may create inappropriate or disjointed care for persons with special health care needs. Risk-adjustment of budgets may disincent cherry-picking behavior and facilitate better care for persons with special health care needs.*	*Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Disease management will provide a care management mechanism for those with particular illnesses. Unclear how well this will work outside the framework of a health plan. Cost-sharing may still pose access issues for persons with special health care needs in employer coverage or those in the CHOICE program who do not participate in disease management. Depending on how implemented, requirement to document medical necessity may also create barriers to services. One group that may potentially be excluded from coverage are those who are near-disabled and unable to work. Lack of dental benefits has potential to be very problematic for persons with certain medical conditions such as HIV/AIDS. Risk-adjustment of budgets may disincent cherry-picking behavior and facilitate better care for persons with special health care needs. Poor disabled protected by continuation of Medi-Cal and Healthy Families.*	*People enrolled in Medi-Cal and Healthy Families will benefit from relatively rich benefit package and disease and care management experience of contracting health plans. Status quo for all coverage groups for limits on access to specialists and services resulting from managed care. People with special health care needs face uncertain benefits and access in employer coverage, particularly if they opt for the new scaled back coverage option. Adults with special health care needs and incomes over 250% of FPL may remain uninsured. Potential barriers from cost-sharing. Lack of care management or disease management mechanism may create inappropriate or disjointed care for persons with special health care needs. Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.) and continued variability of benefits in employer coverage may generally limit access to services for people with special health care needs.*
Rural populations Proposal	Proposal envisions free choice of providers. Transportation not a covered service except for the disabled. Possibility to address rural health care issues by adjusting reimbursement rates.	No particular provisions to address rural access issues. Proposal envisions free choice of providers. Transportation not a covered service, except to the extent covered for Medi-Cal eligible population.	No particular provisions to address this area.
Impact	*Free choice and better reimbursement of providers will facilitate rural access, although provider distribution still potentially problematic. Lack of reimbursement for transportation could pose issues.*	*Free choice of providers and better reimbursement will facilitate rural access, although provider distribution still likely problematic. Lack of reimbursement for transportation could be problematic.*	*Lack of reimbursement for transportation could pose issues. Healthy Families and Medi-Cal opt out of managed care in some rural areas. This will partly address rural access.*

	Shaffer	Spelman	Wulsin
Immigrants and ethnic minorities Proposal *Impact*	Undocumented immigrants are covered. Translation and interpretation services not specifically covered, although author states that cultural competence in care delivery is an objective. Not clear how that will be pursued. Local and regional health planning functions are put into place. The Department of Health (including the Office for Multicultural Affairs and Office for Women's Health) has service delivery functions for special populations. *Main advantage of plan is providing coverage regardless of immigration status. Lack of funding and reimbursement for translation/interpretation could be problematic. With more organized care system and regional input and planning, potential to better match patient populations with services they need. Acculteration to health system may be easier in single player health system.*	Undocumented immigrants are covered. Translation/interpretation a covered benefit. The author outlines an approach to improve cultural and linguistic considerations that includes adoption of standards including cultural competency training, availability of interpreters and translation of written materials. To address public charge fears, enrollee information would not be shared with the INS. *Main advantages of plan are providing coverage regardless of immigration status, covering translation/interpretation and introducing a system-wide strategy for addressing cultural competency. Acculteration to health system may be easier in single player health system.*	Undocumented immigrants covered in the tax credit portion of the reform, but they cannot get coverage through the other components. Funding of translation/interpretation and services to assure culturally competent and linguistically appropriate care generally present in Medi-Cal. *Substantial subgroup of immigrants likely to remain uninsured because of limited mechanisms to cover them. Lack of funding and reimbursement for translation/interpretation in private coverage could be problematic. Author states that it will be important to deliver good, clear information to vulnerable groups and that plans and providers will need to improve language and cultural access. Not clear how this will be accomplished.*
Persons with special health care needs Proposal *Impact*	Specialists can provide primary care services for persons with complex conditions. Patients can choose any provider. Budgets will account for population need and case mix. Case managers/patient navigators will help coordinate care. *Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Comprehensive benefit package and lack of cost-sharing particularly beneficial for persons with special health care needs. Possibility of primary care management by specialists. Direct access to specialty care unless redistribution and recalibration of specialty/primary care ratios or budget based interventions create more limited specialist access. No developed disease management program, although focus on coordination through case managers. Potential for better coordination of care by group practices.*	Patients can choose any provider, although presume that patients who choose an integrated delivery systems will need to remain in network. Author indicates that specialists can provide primary care for persons with special health care needs. Uniform and broad benefits and no cost-sharing. Budgets for facilities and integrated delivery systems (as well as global budgets) will be risk-adjustment. Risk adjustment methodologies outlined. *Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Comprehensive benefit package and lack of cost-sharing particularly beneficial for persons with special health care needs. Possibility of primary care management by specialists. Specialist referrals may be needed in some cases. Lack of specialized care management or disease management approach for persons with special health care needs have potential to create inappropriate or disjointed care. Risk-adjustment of budgets may disincent cherry-picking by providers and facilitate better care for persons with special health care needs.*	Care for publicly insured and likely privately insured provided through managed care (except in rural counties) with attendant restrictions on access to services. Enrollees will likely not have direct access to specialists. Disabled persons currently enrolled in Medi-Cal will transition from fee-for-service to managed care. Plan payments are risk-adjusted in some if not all of Medi-Cal managed care program. Guaranteed issue for individual coverage. *Those enrolled in Medi-Cal and Healthy Families will benefit from relatively rich benefit package and disease and care management experience of contracting health plans. Disabled group transitioning to managed care may experience transition issues and potentially reduced access to services. People with special health care needs face uncertain benefits and access in employer coverage, particularly if employers adopt the minimum benefits (no dental or vision care) for tax subsidy eligibility. Adults with special health care needs and incomes over 133% of FPL may remain uninsured. Cost-sharing may still pose significant access barriers.*
Rural populations Proposal *Impact*	Mechanism to redistribute providers to achieve equitable geographic access. Local input through patient groups into health planning process. Proposal envisions free choice of providers. Transportation not a covered service. *Potential to improve rural access through redistribution of providers and health planning. Free choice of providers will facilitate rural access. Lack of reimbursement for tranportation could be problematic.*	Proposal envisions free choice of providers, although referrals may be needed for specialists. Transportation listed as a covered service. Author states that the distribution of provider and hospital service will be monitored, and financial incentives introduced to improve provider distribution. Weighted budget formulas can address rural service shortages. The proposal includes development of a referral system for people in rural areas. *Free choice of providers, weighted budgets and referral system will facilitate rural access.*	Proposal doubles the CMSP funding. *Provider access per status quo in rural areas. Lack of reimbursement for transportation could pose issues. Medi-Cal and Healthy Families opts out of managed care in some areas. This will partly address access issues. Additional funding for rural areas through increase in CMSP funds.*